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## **Home Care for Older Adults During the COVID-19 Pandemic: Lessons from the Netherlands, Denmark, and Germany to strengthen and expand home care in Canada**

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## Executive summary

This Issue Note summarizes our understanding of how the pandemic has affected the home care sector in Canada compared to three countries with well-developed home care services: the Netherlands, Denmark, and Germany. Lessons for Canada draw from both the published literature and consultations with experts.

### Question

Looking to international exemplars as compared to Canada, what impact (if any) has the COVID-19 pandemic had on home care for older adults in other countries?

1. What vulnerabilities did the pandemic expose in home care in those countries, if any?
2. What structures were already in place in those countries prior to the pandemic that either (a) protected home care during the pandemic or (b) were adapted/pivoted to enable more home care?
3. What effect, if any, did the pandemic have in those countries on quality of home care, support for home caregivers, and home care workforce stability?
4. What lessons can Canada learn from these jurisdictions to inform future planning aimed at strengthening and expanding home care?

### Summary of pandemic effects on home care in Canada, the Netherlands, Denmark, and Germany (see Country Profile for details):

The main insight about home care in the Netherlands, Denmark, and Germany is that sooner or later everyone sits down to a banquet of consequences. Prior to the pandemic, these comparator countries had invested heavily in a robust, comprehensive, and integrated home care infrastructure for those choosing to ‘age in place.’ This meant that many older adults were supported at home rather than in congregate care facilities. Yet, even with this strong foundation, the pandemic has exposed vulnerabilities in their home care systems, as it has in Canada.

We conclude that improving access to home care would allow more Canadians to ‘age in place’ and is, thus, an important part of ‘building back better’ from the COVID-19 pandemic. The main lessons for Canada are that we ought to urgently reconceptualize care for older adults to move away from a binary approach to aging, where many Canadians either struggle on their own to live at home, sometimes supported by unpaid family/friend caregivers because they don’t qualify for publicly-funded support (or for a sufficient amount), or they move to a long-term care facility where they do qualify for paid support. This would involve building up and professionalizing the home care labour force so that more care can be deinstitutionalized, designing, and implementing national home care standards supported by enabling legislation, and redistributing (and possibly increasing) funding to provide more supports to more older adults so that we can remain at home as long as possible as we age.

But we can’t leap a chasm in two steps. More home care, alone, is not sufficient: as proven elsewhere, it must be part of a suite of initiatives that invests in all services that support the quality and safety of our lives as we grow older. As with any system design, we cannot just pluck selected features or policies from the health, social, and long-term care (LTC) systems in other countries and expect the same outcomes. But we can learn from them. If Canada hopes to achieve the same benefits and outcomes for older adults as in the Netherlands, Denmark, and Germany, then our home care system needs to be adapted and refined to look more like theirs.

### Limitations

This report has several limitations, some due to the rapid timelines for production:

- Gaps in the literature due to few published peer-reviewed studies to date and no reviews or syntheses of existing evidence.

- Reliance on 'real world' evidence and perspectives from selected key informants, which may not represent all views and experiences. We spoke with key informants living and working in each country, except Germany where we relied on informants outside of Germany.

## Introduction

Although it is now well-known that many of Canada's long-term care facilities<sup>a</sup> were ravaged by the COVID-19 pandemic, especially in the first and second waves, less evidence is available on what effects the pandemic has had on home care services and supports for the many older adults who are 'aging in place'<sup>b</sup> with support from family/friend caregivers<sup>c</sup> (unpaid or unpaid), other volunteers, and/or paid professional home care workers.<sup>d</sup>

In this Issue Note we explore what impact (if any) the pandemic has had on home care for older adults in other countries—including the Netherlands, Denmark, and Germany—as compared to Canada. We consider the following:

- Any effects on quality of home care, support for home family/friend caregivers and paid professional home care workers, and home care workforce stability.
- Features or structures in place pre-pandemic that either helped to protect home care during the pandemic or enabled it to adapt to increased demand so that older adults living at home could continue to receive support.
- Vulnerabilities—cracks in the home care system—the pandemic has exposed.
- Lessons for Canada to inform planning aimed at strengthening and expanding home care.

## Methods

During our preliminary discussions with Canadian experts, a few countries stood out among 26 Organisation for Economic Co-operation and Development (OECD) comparators as relatively high performing in long-term care generally, and home care specifically: the Netherlands, Denmark, and Germany. We considered both qualitative and quantitative data, employing a mixed-methods approach to produce this rapid review. First, we undertook an evidence scan by searching several databases (Appendix 3: Sources and Sample Search Strategy). Given the time available, we searched for evidence using a hierarchical approach in which we prioritized evidence syntheses, integrative/narrative reviews,

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<sup>a</sup> We mostly use the generic term 'facilities' throughout this report. However, when describing jurisdictions that uses other terms, we use local language too. Even across Canada different terms are used to describe residential long-term care settings. "Within Canada, long-term care homes are facilities that provide 24-hour functional support for people who are frail, require assistance with their daily activities and often have multimorbidity. Most residents of long-term care are over 80 years old and 70% of them have dementia. Across the provinces and territories, these facilities may be known as long-term care homes (in Ontario, Saskatchewan, British Columbia, and Yukon), nursing homes (in Nova Scotia, and New Brunswick), personal care homes (in Newfoundland and Labrador as well as Manitoba), long-term care facilities (in Newfoundland and Labrador, Prince Edward Island, British Columbia, and Northwest Territories), residential care facilities (in Nova Scotia, Alberta and British Columbia), special care homes (in New Brunswick and Saskatchewan), continuing care facilities (in Northwest Territories), or continuing care centres (in Nunavut). In the province of Québec, they are known as centres d'hébergement de soins de longue durée (CHSLD)."(1)

<sup>b</sup> We use the definition of 'aging in place' endorsed by the Federal/Provincial/Territorial Ministers Responsible for Seniors Forum as follows, "Aging in place' means having access to services and the health and social supports you need to live safely and independently in your home or your community for as long as you wish or are able."(2) This definition is consistent with CDC's definition as "The ability to live in one's own home and community safely, independently, and comfortably, regardless of age, income or ability level."(3)

<sup>c</sup> We use the term 'family/friend caregiver' and, where relevant, note whether they are paid or unpaid. This may include anyone within 'informal' social networks, such as relatives, friends, acquaintances, colleagues, or neighbours.(4)

<sup>d</sup> We use the term 'paid professional home care worker' to mean 'formal' services provided by health and social care organizations.(5,6)

guidelines, and systematic reviews. Since no reviews or synthesis reports were found, we relied on selected single studies that we judged to be credible based on the journals in which they were published. We hand-searched reference lists of selected sources. Second, we used Google to search the grey literature for reports, policy literature, white papers, and government documents; we critically evaluated these sources including the authority and objectivity of their authors.<sup>(7)</sup> Third, we undertook in-depth, one-on-one, open-ended, telephone interviews with key informants in the LTC sector, both in Canada and globally, recording case notes during the interviews (Appendix 2: Consultants).

## Limitations

This report has several limitations, mainly due to short timelines. Most important is the fact that in the nearly two years since the WHO first declared the COVID-19 pandemic on March 11, 2020, although much has been learned from the media, government reporting platforms, and published literature about the impact of SARS-CoV-2 in long-term care facilities, little about the effects on home care has been published in peer-reviewed journals, governmental reports, or by non-governmental organizations (NGOs). As such, we also sought 'real world' evidence from selected system leaders recognizing that the perspectives of these key informants may not represent all views and experiences in a particular country. Although several members of the CanCOVID team contributed to study selection, only a single experienced reviewer screened the evidence, without verification by a second reviewer. Validation procedures included triangulating to corroborate or refine our findings, seeking disconfirming evidence, and member checking with our key informants to confirm accuracy and resonance with their experiences.

Despite these limitations, we are confident in the credibility of the sources we consulted. As such, though we urge some caution in interpretation, we suggest it is reasonable to give weight to our findings when crafting policy related to home care.

## Results

We describe our understanding of the state of home care both prior to and during the pandemic in four countries—Canada, the Netherlands, Denmark, and Germany—with key points summarized in Table 1.

Although there is considerable published evidence on the impact of the COVID-19 pandemic on long-term care facilities (8), insights on home care, specifically, are quite limited.

In selecting comparator countries, we relied on evidence from the SHARE survey (Survey of Health, Ageing and Retirement in Europe) of 52,000 older adults in 23 European Union (EU) member states and Israel showing the extent to which the pandemic changed the supply of paid and unpaid caregivers for older adults receiving home care.<sup>(6)</sup> In Wave 1, a significant proportion of older adults in these 23 countries received less home care service from paid providers, substituting more unpaid help from children, neighbours, friends, or colleagues. In most countries, unpaid care was more pandemic-resilient than home care services delivered by paid care providers. Two European countries stand out in reporting the least amount of difficulty in receiving home care during the pandemic—the Netherlands and Germany. By far, the two most fully developed LTC social insurance programs in the world are those in the Netherlands and Germany.<sup>(9)</sup> We report on these two countries, plus Denmark, as compared to Canada.<sup>(6)</sup> We included Denmark because although their survey results show more difficulties in receiving home care than in the Netherlands and Germany, Denmark also has one of the most well-developed home care systems in Europe since deinstitutionalizing long-term care in the 1980s. Key informants also led us to believe that the Danish home care system continued to perform close to normal during most of the pandemic.

Where we report comparative spending on LTC in these four OECD countries, the figures include the sum of both long-term care (health) and long-term care (social) spending. LTC (health) includes medical or nursing care and personal care services, both inpatient and home-based. LTC (social) includes assistance services that enable a person to live independently at home (e.g. shopping, cooking, housework) and also subsidies for residential services in assisted living facilities and expenditure on

accommodation. LTC services may be provided by a range of health professionals and institutions, but also by paid family/friends if a care allowance is permitted. Uncompensated work performed by 'informal' family/friend carers is excluded.(10)

To show the range of long-term care structures used in other countries, we include (with permission) a highly informative table (Appendix 1: Effects of COVID-19 Pandemic on Home Care in 5 Countries)(9) that analyzes and compares long-term care services and supports in Germany, the Netherlands, South Korea, USA (Washington State, Medicaid), Denmark, Sweden, England, and France.

## Country Profiles

### Country name: Canada

#### What was the state of home care in Canada before the pandemic?

Prior to the pandemic, an estimated 881,800 Canadian households (6.4%) reported that at least one person received publicly-funded home care services.(11) A higher percentage of households in Nova Scotia and Québec received publicly-funded home care compared to the rest of Canada; Saskatchewan, British Columbia, and Yukon had fewer home care recipients.(11)

Services are either professionally delivered 'home health care' services, such as nursing care, physiotherapy, occupational or speech therapy, social work, and nutritional counselling, or 'support services' provided by paid personal support workers and/or volunteer agencies to help people with various daily tasks such as bathing, meal preparation, housekeeping, or transportation.(11) These services, delivered in private homes, residential care settings<sup>c</sup>, or ambulatory clinics, may include short-term care and rehabilitation for those recovering from surgery or acute medical conditions, or long-term care and support to enable those with chronic conditions to continue living in the community, or end-of-life care.(13)

In 2017 Canada spent 1.3% of GDP on publicly-funded LTC, of which only 0.2% was spent on home care, one of the lowest allocations to home care in the OECD.(14) Prior to the pandemic, among households in which at least one person of any age received some form of paid professional home care services, 52% received home care services that were paid solely by government. Among those households receiving only home health care services, 65% was publicly-funded but 44% paid for these services out-of-pocket.(11) This disparity in publicly- vs -privately-funded home care exists because, unlike physician and hospital services, home care services are not guaranteed under the Canada Health Act (CHA). Instead, home care is paid for through a patchwork of funding, with some services funded by provincial/territorial governments, some by the federal government to designated populations, and much of it is privately funded by those who do not qualify for publicly-funded support. Canada is one of the few OECD countries that does not generally allocate public funds to the kinds of common household tasks that enable older adults to live independently, such as shopping, laundry, cooking, ordering groceries, and housework.(15) Assistance with these instrumental activities of daily living (IADLs) is as important as assistance with activities of daily living (ADLs) like dressing and bathing.(16) The organization and financing of home care is a topic of ongoing discussion in Canada.(17,18)

But these data only represent paid home care services and don't include help from unpaid family, friend, or neighbour caregivers. In 2012, Statistics Canada estimated that, at some point in their lives, about 13 million Canadians over the age of 15 serve as unpaid caregivers to family or friends who have age-related health needs.(19–21) That's about 40% of those over the age of 15 years. In 2018, approximately 25% of Canadians aged 15 years and older (7.8 million people) "provided care to a family member or

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<sup>c</sup> Residential care settings encompass a range of living options, with varying terminology used across Canada. This includes lodges, assisted living, supportive housing, long-term care homes, nursing homes, personal care homes, and retirement residences. These facilities offer varying levels of care and may be free-standing or co-located within other types or care facility including hospitals. Funding may be public, private, or mixed.(12)

friend with a long-term health condition, a physical or mental disability, or problems related to aging.” Close to half of family/friend caregivers (47%) cared for a parent or parent-in-law.(22) The number of older Canadians needing support from caregivers is projected to more than double by 2050, yet there will be close to 30% fewer family members potentially available to provide unpaid care.(19)

On top of the increasing demand for home care by virtue of demographics alone, the Canadian Institute for Health Information (CIHI) estimates that about 11% of current long-term care residents—1 in 9 residents, roughly 5,000 people—could potentially be cared for at home.(23) BC’s Senior’s Advocate estimates that number is even higher in BC: up to 15% of long-term care residents—4,200 long-term care beds in BC alone—or 1 in 7 current residents could be living in the community with home support and/or assisted living.(24) Other estimates vary from 20% to 50%.(25) CIHI’s Director of Health System Performances says that “staying at home for as long as possible can offer a better experience for many people and can help ensure that long-term care beds are reserved for those with complex needs who require full-time care.”(23) Living in long-term care facilities is expensive: in BC, on average, “a long-term care bed costs taxpayers \$27,740 more per year than two hours of daily home support.”(16) Why, then, are so many people living in institutional care when they’d rather be at home? Because there are barriers to remaining at home. Barriers that can lead to early admission to a long-term care facility instead of home care include the following (23):

- difficulty navigating the health care system
- lack of continuity across the health care system
- lack of single point of access for subsidized home care services and home care supports
- financial barriers and high out-of-pocket costs due to the relative lack of public funding for home care-related services, especially for those living in rural or remote areas
- high out-of-pocket costs for home adaptations
- lack of system responsiveness including reliability of home care support workers
- inflexibility in existing home care services and care plans to accommodate changing care needs
- narrow eligibility criteria for accessing home care
- lack of access to special services such as for social and emotional support (including those aimed at relieving social isolation and loneliness), culturally- and linguistically-tailored services, and help with non-medical needs
- over-reliance on unpaid family/friend caregivers and other volunteers to manage care

### **How has the pandemic affected home care in Canada?**

Home care across Canada is a patchwork of funding and services, with considerable variability between provinces/territories. As such, generalizations about the impact of the pandemic may not apply everywhere, and some jurisdictions appear to have handled the pandemic better than others.

In all Canadian jurisdictions access to both publicly-funded home health care and publicly-funded support services is contingent on completion of an initial screening and/or full assessment to determine care needs. This often takes place in-person in the client’s home. Early in the pandemic, home care providers temporarily changed assessment methods to avoid close contact with clients, and some home care clients suspended their services to limit their risk of infection.(26) The number of screenings and full assessments for clients living at home declined during Wave 1, and those that did take place were completed by phone. Among Ontario’s community-dwelling adults living with dementia, publicly-funded home services were disrupted during the early months of the pandemic in 2020, with larger declines in therapies (50%), moderate declines in personal care (16%), but nursing care was only “minimally impacted.”(27)

As of November 2020, CIHI reported that it was unknown whether some people were unable to start home care services, or what the consequences were of not being able to start home care, or how the provision of home care services was impacted by COVID-19. On December 9, 2021, CIHI reported that there were no updates since 2020 to the home care services data.(26)

Survey data from Fall 2020 show that in Ontario and Québec the pandemic had “dramatically changed perceptions, preferences, and ultimately the financial behaviour of Canadians when it comes to long-term care”: 72% of respondents ages 50-69 said they were less inclined to move into a long-term care facility and favoured home care instead; 25% said they planned to save more for ‘old age’; and 70% favoured tax policy that would subsidize home care in the post-pandemic era.(28)(29) Other survey data from Summer 2020 show that almost 100% of Canadians age 65 years and older report that they plan on living safely and independently in their own homes as long as possible.(30)

Among home care clients and their caregivers located in Ontario and Nova Scotia and surveyed March-June 2020, “participants were affected drastically by the elimination or reduction of access to services, highlighting the vulnerability of home care clients and their caregivers during COVID-19,” and the pandemic “took an emotional toll on home care clients and increased the need for family/friend caregiver support.”(31) Clients and caregivers cancelled services for many reasons, including “different home care workers being assigned to one client,” “home care workers also working in nursing homes,” or having a “home care worker who tested positive for COVID-19.” Workers often cobbled together work from more than one agency (or worked independently) due to a lack of centralized labour direction across the decentralized home care system, leaving many professional home care workers (and unpaid family/friend caregivers) without coordinated access to personal protective equipment (PPE). This resulted in increased risk to workers, their clients, and the households of both groups.(32) There was varied use of virtual care support, in the form of Passive Remote Monitoring Technology, with some reporting less use (if family members replaced paid caregivers), some reporting more use (if family members did not live with the home care client), and some reporting no change.(31)

In Ontario, about 900,000 people receive home care every year, including 730,000 in the publicly-funded system. Yet, Home Care Ontario reports that 3,000 nurses, skilled therapists, and personal support workers moved from home care to other parts of the health care system. Prior to the pandemic, 95% of requests for home care could be fulfilled; as of October 2021 that fell to 60%, representing a “huge cannibalization” of Ontario’s home care workforce, especially nursing.(33) This is expected to worsen because of looming surgery backlogs given that hospital lengths of stay will necessarily increase if patients aren’t able to go home without support.

## **Country name: Netherlands**

### **What was the state of home care in the Netherlands before the pandemic?**

The Netherlands entered the pandemic with a comparatively robust, long-standing, and well-funded home care infrastructure that helped protect access and enabled adaptation as the pandemic evolved. Unlike in Canada, community-based care is the norm in the Netherlands.(34)

The evolution of long-term care services and supports in the Netherlands was reviewed in a previous report.(8) The Netherlands was the first country in Europe to introduce compulsory social health insurance for LTC in 1968. Guided by national legislation, coverage for LTC is provided and organized by the Dutch government, with local authorities and municipalities responsible for the delivery of LTC services in institutions, nursing homes, residential homes, and communities through home-based nursing care. Independent regional care offices (in 32 care regions) contract with residential LTC providers in their region. Social care is purchased and organized by municipalities. The Netherlands is one of the highest spenders on long-term care among OECD nations at €20 billion in 2017 (35) with public spending at 3.7% of GDP (2017) compared to 1.3% of GDP in Canada.(14)

In 2015, after almost two decades of political discussion and reports (36), reforms in long-term care—major overhauls—were implemented to simultaneously reduce spending and promote/support more ‘aging in place.’(37) By way of three key legislative acts, long-term care was radically reoriented. The basic principle of this decentralizing reform is “local as far as possible; regional where necessary.”(38)

First, the location of care shifted such that more care now occurs at home (preferably provided by ‘informal’ family/friend caregivers, either paid or unpaid) and less in institutions. Second, care was decentralized, with municipalities taking responsibility for social care (initially with a reduced budget based on the assumption that locally organized care would be more efficient). This reform was not without controversy in the early stages given the expectation of substantial savings. Dissatisfaction and concerns initially raised about quality of care resulted in new investment in long-term care.(39) Third, health insurers took over responsibility for contracting community nursing, with district nurses playing a key role in integrating different aspects of care and support. Boundaries between the three regimes are not always clear-cut which has created coordination challenges and opportunities for cost-shifting from one regime to another.(40)

National legislation underpins the Dutch long-term care ecosystem through these three Acts:

1. Long-term Care Act
  - Also known as Wlz, this national Act covers the most vulnerable who require 24/7 supervised care in long-term care facilities or at home. These services are funded through both a compulsory long-term care health insurance policy with a 9.65% levy on all taxpayers to a maximum amount per year and income/wealth-based co-payments.(38) Standards are set nationally.
2. Social Support Act
  - Also known as Wmo, this Act is designed for those who need some help—such as meal and transportation services, funding to adapt homes, community day care—but who do not require or qualify for care that falls under the Long-term Care Act; these services are funded through taxes and income/wealth-based co-payments.
3. Health Insurance Act
  - Enacted in 2006, this Act covers direct health care, activities of daily living, and personal care through compulsory health insurance policies offered by 23 competing private not-for-profit cooperatives (‘managed competition’) and is financed through payroll taxes, general taxes, community-rated premiums, and co-payments.

Of those age 85+, one-third (30%) use services under the Long-term Care Act and one-third (30%) under the Social Support Act. Under all three Acts, people have the option to receive care ‘in-kind’ or they may (with permission) opt for a personal budget (*Persoonsgebonden Budget*, or cash-for-care) to arrange their own care/support provided by ‘informal’ paid family/friend caregivers or ‘formal’ paid professional home care workers.(41,42) In 2016, about 14,200 personal budget holders each received around €20,000 annually (35) (~\$28,000 CDN at January 2022 exchange rates).

Since 2015 there have been efforts to scale down the number of people living in what the Dutch call ‘nursing homes,’ ideally to the last one to two years of life, instead putting resources into enabling people to live at home longer through investment in community nursing and other geriatric/older adult services.

### **How has the pandemic affected home care in the Netherlands?**

Dutch district nurses provide rehabilitative, preventive, and supportive care to older adults in the Netherlands, assisting them with medications, activities of daily living, wound care, and end-of-life care.(43) When the pandemic began in March 2020, evidence from one small study of Dutch district nurses shows that nursing care for community-dwelling patients was “often downscaled to a minimum” either because patients rejected care for fear of contracting COVID-19, or they didn’t need care because of delayed surgeries, or care was not available due to the unavailability of nurses.(43) Some patients learned to use healthcare aid devices and technology to replace in-person care. Within the year, service levels in home care had mostly returned to normal levels except when there was insufficient staffing levels or higher demand arising from delayed or changed care needs. There was, however, a greater focus on care that enabled self-reliance and self-management.

Dutch district nurses experience the same stresses as nurses everywhere, but they were also recognized for their adeptness at translating policy guidelines into practical guidelines, and for their ability to “handle complex care and set up different workarounds and innovative collaboration among various organizations.”(43) In other words, they appear to have been empowered, appreciated, and treated like the professionals they are, which helped with workforce stability. The same cannot be said for paid non-nurse home caregivers who struggled to get PPE in the early months of the pandemic.(44)

Unpaid ‘informal’ family/friend caregivers stepped up when they could to fill gaps, especially after PPE became more available in Wave 2, and paid ‘formal’ professional care workers (mostly nurses) “experienced more contact and teamwork with informal caregivers.”(43) More care was provided at home because social and day care services closed down. This shift in location of care had a “high impact on [unpaid] caregivers” who became the “forgotten healthcare workers.”(43) Increased pressure on unpaid caregivers during the pandemic has sparked questions about whether there should be an intermediate option between living at home and in a LTC facility.

Among 11 high-income countries, older adults in the Netherlands reported the least difficulty (11%) getting help with instrumental activities of daily living (IADL) from either paid professional care workers or informal (often unpaid) family/friend caregivers; Canada reported the most difficulty (31%).(45) IADLs include housework, preparing meals, managing daily medications, or shopping, which are among the kinds of services provided through the Dutch Social Support Act.(45)

## **Country name: Denmark**

### **What was the state of home care in Denmark before the pandemic?**

Unlike in Canada, long-term care, including home care, is an integral part of Denmark’s publicly-funded health care system, following the principle of universality and comprehensiveness in the Nordic public service model. Like all the Nordic countries that pioneered long-term care services and supports, Denmark’s system is “built on the same conceptual foundations as their broader social policy regimes: universal coverage, comprehensive benefits (with no or low-copayments), state responsibility replacing family responsibility, and local autonomy in administration.”(9)

The hallmark of Denmark’s long-term care system is a high level of decentralization, enabled by legislation. National legislation sets broad framework and standards for service provision, but 98 municipalities within 5 administrative regions are responsible for long-term care policies, including establishing criteria for eligibility/entitlement and provision/regulation of service delivery.(46) As such, though decentralized, care is also highly integrative.

Care is mainly free at the point of service, delivered by a mix of public and private providers, and financed through general taxation. Public spending in Denmark on LTC comprises 2.5% of GDP, surpassed only by the Netherlands (3.7% in 2015) and Sweden (3.2%).(14) Other Nordic countries spend similarly, with Norway devoting 3.3% and Finland 2.2% of GDP in 2017.(9) By comparison, in 2017 Canada spent 1.3% of GDP on publicly-funded LTC, of which only 0.2% was spent on home care.(14) Relative to these exemplars, and to the average of 1.7% across 17 OECD countries,(9) Canada lags in public spending on LTC.

During the 1970s, Denmark was one of the first European countries to deinstitutionalize long-term care and replace it with community-based solutions.(47) Denmark’s home care policy is the most generous among Nordic countries, measured in the proportion of those age 80+ years receiving home care (34% in 2018) vs. nursing home care (12% in 2017). Among those aged 65+ years, about 11% receive home care.(48)

More than two-thirds of older adults who need long-term care receive support in their own homes, such as activities of daily living, and person-centred reablement (49) (restorative care) to maintain or regain the skills to continue living independently.(46) The Danish perspective that guides reablement is to “add life to

remaining years, not years to remaining life.”(50) Danish municipalities must conduct “annual home visits for all adults over 75 to identify those at risk for frailty in need of home care services and a reablement training program.”(51,52) Since 1996, this entitlement to annual ‘preventive’ visits from a case manager employed by the municipality is intended to “evaluate individual needs and assist with planning independent living.”(53) Since 2015, by law all Danish municipalities must assess the potential for reablement and provide the necessary services through a multi-disciplinary team including social workers, physio- and occupational-therapists, dieticians, and nurses.(51) Most home care is provided by paid professional home care workers, though unpaid family caregivers also provide valuable support.(53) Most of the long-term care workforce comprises “social and health helpers and assistants,” with physiotherapists and occupational therapists having also grown in numbers and influence in the past decade, “especially after the reablement program was implemented.”(46)

Access to home care is enabled by the absence of cost sharing and means-testing at the point of service for home-based care. Around one-third of home care providers are for-profit, but home care and preventative home visits are still free at the point of service.

### **How has the pandemic affected home care in Denmark?**

There is little published peer-reviewed evidence nor are there many government or NGO reports on how the pandemic has affected home care in Denmark. This, in and of itself, seems perhaps diagnostic: as one key informant reported, “It has been mostly business as usual in home care. People have continued to receive the care and service that they are used to.”<sup>f</sup>

Early in the pandemic, when hospital capacity was the focus of the Danish national government’s attention, there was less focus on the work of municipalities in Denmark’s home care sector with local reports of some services not being delivered.(54) These reports occurred in the early chaotic months of 2020, in spite of consistent political focus on protecting the most at risk people, exposing vulnerability in the home care system. When this was realized, efforts quickly shifted to also protecting those receiving home care and those living in long-term care facilities. This shift was enabled because home care is holistically integrated into the rest of Denmark’s health and social care system, rather than functioning as a separate component as is more common in Canada.

What factors enabled services to continue in home care? The Danish home care system mostly managed to continue providing services that were essential for health and safety because of a high degree of professionalism and, therefore, loyalty, in the home care workforce. This was coupled with a high degree of solidarity among the Danish population. The result was that home care workers and their clients were prioritized for vaccines, regulations were implemented to improve safety including the same person caring for the same clients and frequent testing of staff, citizens volunteered to help with home care(55), those normally working in health administrative positions and retired people volunteered to deliver PPE to families of home care clients and to the clients themselves, and home care clients willingly postponed some services like house cleaning. Consequently, demand for home care stayed about the same as always and the system has mostly been able to meet demand throughout the pandemic. That isn’t to say that it has been easy all along: As of February 1, 2022, the infection rate in Denmark from the Omicron variant was higher than ever before, with purportedly the second highest number of new confirmed cases in the world.(56) Like in much of the world, time will tell whether this stresses Denmark’s health and social care systems. Meanwhile, effective February 1, 2022, Denmark lifted most COVID-19 restrictions, no longer considering it a “socially critical disease.”(57) A survey of home care recipients is planned for 2022 to formally assess the pandemic’s effects.

Two other features, beyond the structure and function of the formal health and social care system itself, may help to explain Denmark’s relative success in keeping the home care system afloat during the pandemic: First, Denmark is culturally a high-trust country. Most Danes “simply followed the advice of the authorities and didn’t take it upon themselves to police others.”(58) Trust has been protected and

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<sup>f</sup> Personal Communication, Louise Weikop, January 20, 2022.

sustained through 'radical transparency' in official government communications, particularly regarding vaccines. Transparency is of key importance for sustaining long-term trust and avoiding the spread of conspiracy beliefs.(59) High vaccine compliance allowed for fewer restrictions, so opposition was not fuelled. Tools such as mass testing and vaccine passports are viewed "not as control tools, but tools for protecting each other and returning to normalcy."(60) Second, a defining feature of Danish cultural identity is the concept of '*hygge*,' which encompasses a "feeling of cozy contentment and well-being through the enjoyment of the simple things in life."(61) Perhaps Danes receiving home care and those helping to care for them didn't mind so much staying home and away from crowds, which may have contributed to less spread of COVID-19, at least in the pre-Omicron waves.(61)

## Country name: Germany

### What was the state of home care in Germany before the pandemic?

The German health care system dates to 1883 when parliament made nationwide health insurance compulsory. Responsibilities for health system governance in Germany are highly complex, involving three levels (federal, state, and self-governing bodies). The federal Ministry of Health is responsible for policy-making through laws and administrative guidelines. States (Länder) are responsible for hospital planning and financing hospital investments. Self-governing bodies include associations of sickness funds and health care providers.(62)

In subsequent years, other risks were alleviated through statutory social insurance for accidents and invalidity (1884), old age and disability (1889), unemployment (1927), and, much later, long-term care (1995).(63) Compulsory long-term care insurance (LTCI) completed the fifth and final pillar of Germany's comprehensive health and social care system, enshrining care for older adults into the constitution.(8)

LTCI funds the cost of care and Germany's 16 states are responsible for securing the infrastructure, including long-term care facilities. Service prices are heavily regulated. National quality standards exist with compliance monitoring and reporting.(64) In 2017, Germany spent 1.5% of GDP on long-term care, serving as a model for other countries by offering robust benefits at a modest cost.(9) By "requiring retirees to contribute to the program throughout retirement (unless and until entering beneficiary status)," Germany has managed to partially mitigate intergenerational inequity, and grandfather in coverage of first generation beneficiaries, while keeping the overall contribution rate low.(9) When new threats to fiscal sustainability or equitable access arise, the German government seems to have enough support across the political spectrum to implement creative legislative reforms that protect the long-term care system.

Compulsory LTCI provides benefits for home care. This includes either cash-for-care benefits (*Pflegegeld*) (to pay a family caregiver) or benefits-in-kind (*Pflegesachleistung*) (for various professional nursing and personal assistance services), or a combination of both types of benefits depending on the level of care needed. German social policy is anchored in the principle of 'subsidiarity,' meaning that the "state will only interfere when the family's capacity to service its members is exhausted."(9) A companion principle is that "the system prioritises care in the least restrictive environment," with 80% of beneficiaries choosing cash benefits (64) and 69% choosing to receive care at home(65). Beneficiaries and their families make these choices (66) assisted by support centres (*Pflegestützpunkte*) that are organized by LTCI funds in partnership with local communities to offer advice and support based on services needed, cost, and quality.(65) Costs not covered by LTCI are paid for by the individual, with assistance from local municipalities for uncovered costs in care homes or for lower income persons.

Other countries have modeled their systems on Germany's, including Japan (in 2000). South Korea's system (2008) is influenced by Germany's and Japan's.(9) One difference, though, is that Japan and South Korea rejected cash benefits largely due to "concerns they would reinforce gendered patterns of work and care and reduce labour-force participation" but also because they were concerned about cost if there were to be a large up-take of cash benefits.(9)

### How has the pandemic affected home care in Germany?

As in many countries, home care for older adults in Germany did not escape COVID-19. Early in the pandemic, one estimate shows that almost half (45.8%) of all home care services were “endangered/unstable” due to insufficient staffing.(67)

Home care already suffered from a shortage of skilled workers and ‘low attractiveness’ of the nursing profession that pre-dates the pandemic, as evidenced by the 2018 ‘Care Staff Strengthening Act’ (*Pflegepersonal-Stärkungsgesetz*) to address issues related to working conditions, income, and working hours.(67) During the pandemic this has been exacerbated by the live-in model of home care in Germany (and Austria and Switzerland too) which relies on mostly (female) migrant caregivers from Central and Eastern Europe who work in pairs and alternate shifts of 2-12 weeks at a time, commuting between their countries of origin in Poland, Romania, and Slovakia.(68) Travel restrictions made this circular migration difficult, exposing vulnerability in Germany’s home care system through the fragility of this transnational arrangement.(67) The pandemic has highlighted the need for initiatives to ensure provision of a stable long-term care workforce, especially in times of crisis.(69) To enhance resilience, one approach would be to implement policies aimed at “formalization and legalization of care services across national borders.”(70)

Effects of the pandemic on home caregivers is mixed. Some report that the pandemic has also strained family caregivers in Germany, who collectively care for about 2.5 million people at home. One analysis reports that among those describing their experiences on social media posts, 71% of family/friend caregivers found it “more difficult to balance caregiving and work,” with 52% reporting a deterioration in their own health and quality of life.(71) This was in large part because many family caregivers turn to day care and short-term respite care facilities, but these relief options were shut down during the pandemic.(71) Legislation passed in May 2020—the “Second Act for the Protection of the Population in the Event of an Epidemic Situation of National Significance” —implemented relief measures for family caregivers, including expansion of the care support allowance.(71,72) Other studies report “no significantly different prevalence of [unpaid] caregiving during the pandemic compared to before,” with few caregivers and few recipients of care infected. Caregiving intensity and time increased, with less ambulatory care but more shopping help.(73)

These effects indicate additional burdens experienced by informal caregivers, with an apparent need for some structural reform to support home care providers and recipients during crises.(74)

Table 1 compares Canada, the Netherlands, Denmark, and Germany, including structures in place prior to the pandemic that protected or enabled adaptation during the pandemic, effects of the pandemic (such as on quality of home care, support for caregivers, workforce stability), and vulnerabilities the pandemic exposed in home care.

**Table 1. Effects of COVID-19 Pandemic on Home Care in Four Countries**

Country	Structures in place that protected home care or enabled adaptation	Effects of pandemic on home care (quality, support for caregivers, workforce stability)	Vulnerabilities the pandemic exposed in home care
Canada	<ul style="list-style-type: none"> <li>Government (federal, provincial, territorial) co-financing and subsidization + user private pay</li> </ul>	<ul style="list-style-type: none"> <li>Considerable disruption to home care services</li> <li>Increased burden on informal unpaid family/friend caregivers</li> <li>Co-mingling of workers in home care and institutional care threatened infection prevention and control</li> <li>“Cannibalization” of home care work force in some</li> </ul>	<ul style="list-style-type: none"> <li>Patchwork of funding, services, and providers</li> <li>Insufficient funding targeted to home care</li> <li>High eligibility bar to access publicly-funded home care</li> <li>Comparative over-reliance on institutional care</li> </ul>

Country	Structures in place that protected home care or enabled adaptation	Effects of pandemic on home care (quality, support for caregivers, workforce stability)	Vulnerabilities the pandemic exposed in home care
		jurisdictions, especially nurses	even when home care is preferred <ul style="list-style-type: none"> <li>• Failure to professionalize paid home care workforce</li> <li>• Insufficient tracking, monitoring, and integration of support provided by unpaid caregivers</li> <li>• Inconsistent use of virtual care and Passive Remote Monitoring Technology</li> <li>• Lack of pandemic preparedness planning (e.g. PPE)</li> </ul>
<b>Netherlands</b>	<ul style="list-style-type: none"> <li>• 3-part integrated legislation (LTC, Health, Social Support) funded through levy on taxpayers + payroll taxes + general revenues + community-rated premiums</li> <li>• Compulsory LTC insurance funded through levy on all taxpayers + sliding scale co-payments</li> <li>• Robust, longstanding, well-funded, integrated, home care infrastructure</li> <li>• National standards</li> <li>• Strong support for community-based district nursing and geriatric services</li> </ul>	<ul style="list-style-type: none"> <li>• Initial disruption in home care followed by return to mostly normal levels</li> <li>• Greater focus on care that enabled self-reliance and self-management</li> <li>• District nurses were adept, empowered, appreciated</li> <li>• Increased pressure on 'informal' unpaid caregivers</li> <li>• Lack of PPE for paid non-nurse caregivers</li> <li>• Increased use of devices and technology to replace in-person care</li> <li>• More teamwork between paid and unpaid caregivers</li> </ul>	<ul style="list-style-type: none"> <li>• Potential need for intermediate level of care in between home and institution</li> <li>• Need for stronger participation of all levels of care, including non-nurse health care workers, in health care management and decision-making</li> </ul>
<b>Denmark</b>	<ul style="list-style-type: none"> <li>• Compulsory standalone national LTC insurance, funded through general revenues</li> <li>• Decentralized but integrated community and home care</li> </ul>	<ul style="list-style-type: none"> <li>• Minimal disruption of home care services</li> <li>• High degree of loyalty and professionalism in home care workforce</li> <li>• PPE available to families of home care clients and citizen volunteers</li> </ul>	<ul style="list-style-type: none"> <li>• Federal government prioritized hospitals more than nursing homes and home care</li> <li>• Shifting of otherwise state-sponsored care to voluntary</li> </ul>

Country	Structures in place that protected home care or enabled adaptation	Effects of pandemic on home care (quality, support for caregivers, workforce stability)	Vulnerabilities the pandemic exposed in home care
	<p>infrastructure (high degree of vertical and horizontal integration of services)</p> <ul style="list-style-type: none"> <li>• Most generous home care policy among the Nordic countries (no cost sharing or means testing)</li> <li>• Person-centred reablement services to support independence</li> <li>• Consistent political support and solidarity for protecting the elderly</li> <li>• Culturally high-trust country enabled governance through cooperation rather than opposition and resistance</li> <li>• ‘Radical transparency’ in government’s official communications sustained trust</li> </ul>		<p>care reproduced gender inequity, with women doing most of the ‘voluntary’ unpaid home care work</p>
<b>Germany</b>	<ul style="list-style-type: none"> <li>• Compulsory standalone national LTC insurance since 1995 funded through payroll tax + user private pay</li> <li>• National quality standards</li> <li>• Choice of cash-for-care and benefits in-kind, or combination</li> <li>• Paid family caregivers</li> <li>• Support across political spectrum to implement creative legislative reforms in LTC</li> <li>• System prioritizes care in least restrictive environment</li> </ul>	<ul style="list-style-type: none"> <li>• Unstable/endangered live-in home care services due to insufficient staffing</li> <li>• Some reports of paid family caregivers having trouble maintaining caregiving and other work</li> </ul>	<ul style="list-style-type: none"> <li>• Heavy reliance on paid transnational caregivers was threatened by border closures</li> <li>• Need to formalize and legalize care services across national borders</li> <li>• Need for structural reform to support home care providers and recipients during crises</li> </ul>

## Discussion

The COVID-19 pandemic has affected home care to varying degrees, and for different reasons, in Canada, the Netherlands, Denmark, and Germany. The extent to which home care is integrated into the health system and sufficiently funded undoubtedly has something to do with that. Notably, the Netherlands is one of the highest spenders on long-term care among OECD nations at 3.7% of GDP (2017) (35), compared to 1.3% in Canada (of which only 0.2% was spent on home care, one of the lowest allocations to home care in the OECD) (14), 2.5% in Denmark (14), and 1.5% in Germany (9). Relative to these exemplars in home care, and to the average of 1.7% across 17 OECD countries,(9) Canada lags in public spending on LTC.

Funding arrangements for home care vary across these comparator countries. Long-term care, including home care, is an integrated part of the health and social care systems in the Netherlands, Denmark, and Germany, enshrined in law. Both Germany and Denmark rely on national long-term care insurance to pay for home care, funded by payroll taxes (Germany) or general revenues (Denmark). The Netherlands relies on three integrated laws that enable wrap-around services for long-term care, health care, and social support, with long-term care funded through a combination of payroll taxes, general revenues, and community-rated premiums. Canada, by contrast relies on a shared funding arrangement between the federal and provincial/ territorial governments, with individuals contributing out-of-pocket in varying amounts according to their ability to pay. Accountability for home care varies across provinces/territories, with a wide array of legislation, policies, standards, guidelines, reporting, priorities, and funding. There is no national long-term care legislation in Canada, nor are there national principle-based(75) standards or a framework for home care (or for long-term care facilities though efforts are underway to change that).(76) For now, as with other long-term care, home care in Canada remains a patchwork of funding, policies, standards, services, and providers.

Each of these countries has many strengths in the intricate ways in which they try to provide home care for older adults; the pandemic has also exposed their vulnerabilities.

- On the one hand, Canada's federal/provincial/territorial arrangement has enabled nimble action at the local level. Yet most public funding for long-term care services goes to those living in institutionalized long-term care facilities, not those living at home. Home care is not governed by the same principles as those enshrined in the CHA. What's left for home care means that access is limited only to those with the greatest need, or those who can afford to pay. This, despite a health care system that otherwise prides itself on access to care based on need, not ability to pay. This, despite a clear expression by older adults in Canada that they would prefer to 'age in place.' As one key informant put it, "What matters is the ability to live a life with connections to families and friends. You can't do that when we use warehouse models."<sup>§</sup> The home care workforce in Canada is filled with compassionate, skilled providers, many of whom are nurses and other skilled professionals from other countries whose credentials are not recognized in Canada. They are often employed by contracted agencies and paid less than their skill set deserves based on how much their equivalent counterparts earn in other sectors of the health care system, such as in long-term care homes or hospitals.(77) There has been considerable disruption to paid home care services during the pandemic, with unpaid family/friend caregivers picking up the slack when they could. We have little routinely collected data in Canada to show how older adults 'aging in place' and their caregivers—both those who receive publicly-funded home care and those who pay privately out-of-pocket—have fared during the pandemic. Fortunately, this is a priority area for the federal/provincial/territorial governments who have worked together to develop a common set of indicators to measure pan-Canadian progress toward improving access to home and community care.(13) These indicators are in support of the shared health priorities agreed to by governments in August 2017 and the accompanying \$11 billion federal investment over 10 years to lead to improvements in these areas.(78)

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<sup>§</sup> Personal Communication, Maggie Keresteci, January 24, 2022.

- The Netherlands entered the pandemic with a comparatively robust, long-standing, and well-funded home care infrastructure that helped protect access and enabled adaptation as the pandemic evolved. Unlike in Canada, community-based care in the Netherlands is the norm because it is integrated into the health system.(34) Dutch district nurses mostly continued to support older adults in the Netherlands during the pandemic, with service levels returning to near-normal, except when there was insufficient staffing or higher demand than anticipated. As in Canada, unpaid ‘informal’ family/friend caregivers picked up the slack where they could. This has sparked discussion about whether there should be an intermediate level of care between living at home and in a facility.
- Home care in Denmark follows the ethos of the Nordic public service model, exemplifying the principles of universality and comprehensiveness. Since the 1970s, long-term care has been deinstitutionalized in Denmark, replaced with community-based solutions, guided by the Danish value of “adding life to remaining years, not years to remaining life.” Like in Canada, home care is highly decentralized, but the difference is that it is enabled and guided by national legislation and standards. Like in many countries, hospitals and long-term care homes were prioritized early in the pandemic, but because home care was so entrenched, there seems to have been minimal disruption. That said, as in many countries, the pandemic has revealed a crack in the Danish system, namely the burden on unpaid family caregivers, mainly women.
- Germany’s home care infrastructure may be the most versatile among these comparators, with national LTC insurance, options to receive cash-for-care or in-kind services or a combination, and payment for family/friend caregivers. On the surface, it looks like a nearly flawless system. But the pandemic revealed a fly in the ointment: Germany’s live-in home care system relies on a transnational migrant workforce commuting from Poland, Romania, and Slovakia. With border restrictions in place during the pandemic, the fragility of this arrangement was exposed. Once again, both unpaid and paid family/friend caregivers picked up the slack. Germany’s challenges include figuring out how to formalize and legalize care services across national borders and buttress their family caregivers in times of crisis.

## Conclusion

Long-standing, integrated, home- and community-based care systems for older adults—with considerable public investment—rather than institutional care, is helping support many older adults during the COVID-19 pandemic who are ‘aging in place’ in the Netherlands, Denmark, and Germany.

In health system design, context matters. The designs of the Dutch, Danish, and German health, social, and long-term care systems are rooted in country-specific characteristics, influenced by culture, values, politics, economics, history, and the structure/style of governance. When the COVID-19 pandemic began, governments in these comparator countries already had long-standing and broad public support for, and, thus, political attentiveness to, the LTC sector. How and why that support evolved as it did is multi-factorial and beyond the scope of this report. We note, for example, that unlike Canada, these comparator countries have all had coalition governments over time. That feature may have enabled broad and enduring public support for implementation of the policy and legal frameworks that underpin their LTC sectors(79), just as Canada’s ‘cooperative federalism’ may have helped coalesce support for the adoption of Medicare and the Canada Pension Plan in the 1960s.(80)

What lessons can Canada learn about the home care systems for older adults in these countries that has helped them cope during the pandemic, to inform our own planning aimed at strengthening and expanding home care?

### Lesson 1: Reconceptualize care for older adults.

- Evidence from the Netherlands, Denmark, and Germany supports the proposition that, “after decades of duct tape solutions, Canada’s provinces need to make judicious use of the wrecking

ball”(25) so as to reconceptualize and redesign the care of older adults, including care for those aging in place at home. Although many countries have struggled to maintain home care services during the pandemic, some countries have done better than others. Those that entered the pandemic with robust, integrated, home care systems appear to have been more resilient to the havoc the pandemic wreaked. This includes policies and legislation that support integration between home care and primary health care.(81,82)

When it comes to caring for older adults, one size does not fit all. Evidence from these three countries suggests that the goals ought not be to abolish LTC facilities altogether, but rather transition away from big institutional models—not build more—and the underfunding of home care that have plagued long-term care for far too long.(83) With better access to more home care supports, we could even potentially de-institutionalize some people who are currently living in long-term care facilities but who would rather be living “at home” if only they had the services they need to regain and maintain more autonomy.

For individuals residing in the community, Canada relies heavily on unpaid care from family, friends, and neighbours. More home care would require a big shift in our philosophy and approach toward aging—a moonshot approach. If we were to start from the premise that many of us will need help if we’re lucky enough to live that long, and that many of us would choose to remain in our own homes if we’re lucky enough to like where we live, then evidence from elsewhere suggests we ought to change course and redesign the system to de-institutionalize care and shift more care toward home to respect that choice.

## **Lesson 2: Move away from the binary approach to aging.**

De-institutionalizing care, as is the norm in all three of our European exemplars, would move us away from the binary approach to aging. As it is now, when we are older many of us either struggle on our own to live at home, sometimes supported by unpaid family/friend caregivers because we don’t qualify for paid support (or for a sufficient amount), or we move to a long-term care facility where we do qualify for paid support. In BC, “the average senior could save \$10,000 per year by living in long-term care versus living at home with home support, but taxpayers would pay an average of \$28,000 more.”(16) Yet, with more public funding for home care options and a lower bar for eligibility—based on need, not income—more of us could age in place, either in our own homes or in community settings such as shared houses, apartments, or naturally occurring retirement communities.(84) In many instances, even relatively small, inexpensive, changes to adapt our homes—like installing shower safety bars, toilet risers, bed rails, mobility aids, and even help with snow shovelling—would make a big difference in a person’s ability to safely age in place. Focusing on reablement services would support more older adults to not only remain at home, but to do so with a better quality of life and more independence. But access to those adaptations is often means-tested, so many people don’t qualify. Comparator countries still offer a continuum of supports so that older people can make meaningful choices about where they live and the care they receive, but they offer more daily supports than we do for those who want to remain ‘at home.’

What if we adopted a feature of Denmark’s system and screened all adults over the age of 75 to identify those who might benefit from home care services? There are many models for this both in health care and elsewhere. Firesmart Canada™, for example, helps homeowners assess their homes for wildfire risk so that they can mitigate and protect their homes and communities, believing that, “The homes that are prepared are the homes left standing.”(85) What if we similarly normalized ‘age-smart’ screenings for home care services and supports to de-stigmatize ‘growing old’ and enable ‘aging in place?’

There are many approaches and philosophies to designing/redesigning systems and transforming the way health care is delivered and experienced.(86) A shift toward more home-centred care would be consistent with the WHO’s framework on integrated people-centred health services.(87) It would cost Canada’s governments less money to support more Canadians at home than funding more long-term care beds in institutions.

**Lesson 3: Urgently develop and implement national standards for home care and any necessary enabling legislative framework.**

- Each of the comparator countries has national care standards with independent compliance monitoring, transparent reporting, and enabling legislation. Although several Canadian provinces/territories have legislation that defines and governs the provision of home care services, not all do. There is wide variability across Canada, with home care legislation “tucked into various acts, orders-in-council, guidelines, and policies.”(88,89) We have been tinkering at the margins for a long time, partly because of our unique division of powers and its effect on matters related to health. As the pandemic has shown us, sometimes the perfect is the enemy of the good. It’s well past time to develop and launch national home care standards—in collaboration with the federal/provinces/territorial governments—just as we are doing to develop safety and quality standards through the Health Standards Organization’s (HSO) National Long-Term Care Services Standard to improve care for those living in LTC facilities/homes.(90)

**Lesson 4: Train more home care workers and professionalize this workforce**

- Labour supply is foundational to home care. As in Canada, home care in the comparator countries relies on a combination of paid and unpaid labour, often women. In Denmark, a high degree of loyalty and professionalism in the home care workforce helped to sustain it during the pandemic. This was also true in the Netherlands where district nurses provide much of the care. In Germany, though, where live-in home care workers travel across borders from nearby countries, border restrictions made it impossible for them to get to work which left those in their care in a predicament. The lesson for Canada is that if we are going to increase access to home care, we need to make sure there’s a stable, professionalized work force to support it, one in which workers are paid at least a living wage with benefits comparable to their colleagues working in hospitals and long-term care facilities, and where they see a career path with a structured approach to training that is packaged around a career ladder with wage progression. We might also consider cash-for-care benefits for family/friend caregivers, such as in Germany and the Netherlands (but not Denmark), provided these arrangements are optional, not expected, for both the older adult and the family/friend caregiver. This choice is especially important given that a greater proportion of women work full-time outside the home in Canada than in Germany and the Netherlands.(91) Without expanding and stabilizing the workforce, we will replicate in home care the long waits for services that characterize other parts of our health care system. This is especially true given the crisis in health human resources we are now facing from the pandemic.

These lessons are not new, but the pandemic has shone a bright light on them. We have known for a long time that the demographics of Canada portend the urgent need to design and implement plans to help Canadians safely age at home for as long as possible. A key role of government is to steward partnerships and build consensus on the system features that are most appropriate.(92) Taking transformative action to expand home care would require courageous political leadership and cooperation at all levels of government. Other countries have mustered that courage to increase support for older adults ‘aging in place’; Canada could too. There is rarely political appetite for risk, but risk comes with the job of governing. As has been said, “A ship is safe in the harbor, but that’s not what ships are built for.” We have seen bold leadership and crisis management demonstrated throughout the pandemic, so we know it’s possible.

We conclude that improving access to home care would allow more Canadians to ‘age in place,’ and is, thus, an important part of ‘building back better’ from the COVID-19 pandemic. The next steps required to urgently reconceptualize care for older adults include building up and professionalizing the home care labour force so that more care can be deinstitutionalized, designing, and implementing national home care standards supported by enabling legislation, and redistributing (and possibly increasing) funding to provide more supports to more older adults so that we can remain at home as long as possible as we age.

But we can't leap a chasm in two steps. More home care, alone, is not sufficient: as proven elsewhere, it must be part of a suite of initiatives that invests in all services that support the quality and safety of our lives as we grow older. As with any system design, we cannot just pluck selected features or policies from the health, social, and long-term care systems in other countries and expect the same outcomes. But we can learn from them. If Canada hopes to achieve the same benefits and outcomes for older adults as in the Netherlands, Denmark, and Germany, then our home care system needs to be adapted and refined to look more like theirs.

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**Appendices**

**Appendix 1: Key Design Features of Long-Term Services and Supports Programs Around the World, by Program Type(9)**

Country (year implemented)	Structure				Financing	Integration	Benefit Type and Setting	Implementation/Governance
	Universal Governance or means tested? Start and duration of coverage	For 65+ only or all disabled? *	Transition cohorts covered. (existing retirees)	Start and duration of coverage				
<b>1. Social Insurance</b>								
Germany (1995)	Universal	All	Yes	Unlimited	Payroll tax of 3.05% on earned income (split between employers and employees) up to a cap of €58,050 (\$70,751) in 2021; <sup>1</sup> pensioners pay full contribution; childless workers' pay supplementary 0.25% contribution; unemployment insurance pays contributions for unemployed	Standalone social LTC insurance	Cash, service, or combined; HCBS & Institutional	National program administered by social LTC insurance funds (organized within the social health insurance funds)
Japan (2000)	Universal	65+; also, for age 40-64 with age-related disability (e.g., dementia)	Yes	Unlimited	50% contributory (split equally between payroll tax and old-age premiums; payroll tax is roughly 1.5% split between employers and employees for those age 40-64 [rate can differ by insurance type] with modest income-related premiums and copayments for those age 65+, defined and different by municipal body); <sup>2</sup> 50% general revenues	Standalone social LTC insurance	Service; HCBS & Institutional	National program, locally administered

Netherlands (1968, reformed 2015)	Universal	All	Yes	Unlimited	Long-Term Care Act (WLZ): Contributory (employee and pensioner payroll tax of 9.65% on earned income up to cap of €34,712 [\$42,307] in 2020) <sup>3</sup> Health Insurance Act (ZVW): 45% contributory (employer payroll tax of 6.7% on earned income up to cap of €57,232 [\$70,264] in 2020); <sup>4</sup> 45% community rated premiums by employees and pensioners; remainder general revenues <sup>5</sup> . Social Support Act (WMO): general revenues	Juxtaposition of 3 un-integrated systems: standalone institutional LTC/ intensive home care (WLZ); integrated health / home health care (ZVW); ancillary LTSS (WMO)	WLZ: Institutional and intensive home care (cash, service, or combined) ZVW: home health care including personal care (service or cash) WMO: ancillary home care supports (cash or service) <sup>6</sup>	WLZ: National and regional ZVW: National governance; national private health insurers contract with local district nursing for integrated home health and long-term care WMO: Local <sup>7</sup>
Republic of Korea (South Korea) (2008)	Universal	65+; also for those under 65 with age-related disability (e.g., dementia)	Yes	Unlimited	60-65% contributory (0.68 % payroll tax** split between employers and employees; 20% tax subsidy; 15- 20% co-payment with reduction/ exemption for low-income beneficiaries. <sup>8</sup>	Standalone social LTC insurance	Service; *** HCBS & Institutional	National program administered by National Health Insurance Service
Washington State (United States) (2022)	Universal	18+	No	Unlimited in time; initial lifetime benefit max of \$36,500	Payroll tax of 0.58% on all earned income. <sup>9</sup>	Standalone social LTC insurance	Service;**** HCBS & Institutional	State program
<b>II. Universal Comprehensive Coverage</b>								
Denmark <sup>10</sup> (late 1940s)	Universal	All	Yes	Unlimited	General revenues	Part of health and social service systems	Service;**** HCBS & Institutional	National system with entirely local/regional funding and local autonomy and heterogeneity in service delivery

Sweden <sup>11</sup> (late 1940s)	Universal	All	Yes	Unlimited	General revenues	Part of health and social service systems	Service;***** HCBS & institutional	National system with primarily local/regional funding and local autonomy and heterogeneity in service delivery
<b>III. Means-Tested Systems (Anglo-Saxon model)</b>								
England <sup>12</sup> (1948, reformed 2015)	Means tested	18+	Yes	Unlimited	General revenues (central and local taxes)	Part of local government services, collaboration with health services	Cash or service; HCBS & Institutional	Locally administered, taking account of central guidance
United States (Medicaid) (1965)	Means tested	All	Yes	Unlimited	General revenues (federal and state taxes)	Part of health insurance system	Service; HCBS & Institutional	Joint federal-state funding and administration with state heterogeneity
<b>IV. Hybrid approach (Combining universal coverage with substantial family responsibility and a minor social insurance component)</b>								
France <sup>1</sup> (Allowance for Personal Autonomy, 2002; National Solidarity Fund for Autonomy, 2005)	Universal, with benefits decreasing as income increases	60+, strict disability criteria (3 ADLs)	Yes	Unlimited	General revenues with small social insurance component	Part of health and social service systems	Cash or service; HCBS & Institutional	National system locally administered

## Notes:

Reprinted with permission from Veghte BW., “Designing Universal Long-Term Services and Supports Programs,” [https://www.nasi.org/wp-content/uploads/2021/06/NASI\\_LTSSProgramsAbroad.pdf](https://www.nasi.org/wp-content/uploads/2021/06/NASI_LTSSProgramsAbroad.pdf), 2021, pp. 6ff.

\*Countries whose long-term care programs do not cover younger people with disabilities have separate programs to address their needs.

\*\*The LTC insurance contribution rate is set at a fixed percentage (10.25% in 2020) of the National Health Insurance contribution rate (6.67% in 2020):  $10.25\% \times 6.67\% = 0.68\%$ .

\*\*\*Cash benefits are very low and only rarely provided, e.g. in areas where service providers are insufficiently available.

\*\*\*\*Family members may be paid for approved personal care services.

\*\*\*\*\* Cash benefits are very low and not universally available.

<sup>1</sup> Federal Ministry of Health, “Beiträge und Tarife,” <https://www.bundesgesundheitsministerium.de/beitraege-und-tarife.html>, accessed January 13, 2021.

<sup>2</sup> The financing of the Japanese long-term care system is based on a complex set of factors that change from year to year. Half of the financing is from general revenues of different levels of government, the other half is contributory. Of the contributory half, adults 65 and older pay close to one half through modest income related premiums structured similarly to Medicare Part B premiums but at much lower levels. The other half is paid by workers aged 40-64 through social insurance contributions matched by their employers. The payroll tax rate for a given year is a function of total system costs. Nanako Tamiya, Haruko Noguchi, Akihiro Nishi, Michael R Reich, Naoki Ikegami, Hideki Hashimoto, Kenji Shibuya, Ichiro Kawachi, John Creighton Campbell, “Population ageing and wellbeing: lessons from Japan’s long-term care insurance policy,” *Lancet* Vo. 378, Nr. 9797: 1183-1192, DOI:10.1016/S0140-6736(11)61176-8; “Die gesetzliche Pflegeversicherung in Japan,” Ministry of Health, Labour and Welfare, February 2013, [https://www.de.emb-japan.go.jp/j\\_info/sozialversicherung/8pflege.pdf](https://www.de.emb-japan.go.jp/j_info/sozialversicherung/8pflege.pdf).

<sup>3</sup> Belastingdienst (Tax Office)

[https://www.belastingdienst.nl/wps/wcm/connect/bldcontentnl/belastingdienst/privé/internationaal/uitkering\\_pensioen\\_en\\_lijfrente/pensioen\\_uit\\_duitsland/premie\\_volksverzekeringen\\_en\\_bijdrage\\_zvw\\_betalen/hoewordtdepremielwz\\_berekend](https://www.belastingdienst.nl/wps/wcm/connect/bldcontentnl/belastingdienst/privé/internationaal/uitkering_pensioen_en_lijfrente/pensioen_uit_duitsland/premie_volksverzekeringen_en_bijdrage_zvw_betalen/hoewordtdepremielwz_berekend), accessed November 7, 2020.

- <sup>4</sup>Belastingdienst (Tax Office), [https://www.belastingdienst.nl/wps/wcm/connect/bldcontentnl/belastingdienst/privewerk\\_en/inkomen/zorgverzekeringswet/veranderingen-bijdrage-zvw/](https://www.belastingdienst.nl/wps/wcm/connect/bldcontentnl/belastingdienst/privewerk_en/inkomen/zorgverzekeringswet/veranderingen-bijdrage-zvw/), accessed December 26, 2020.
- <sup>5</sup>Pieter Bakx, Erik Schut, and Bram Wouterse, “Price Setting in Long-Term Care in the Netherlands,” Erasmus School of Health Policy and Management, November 2020; Wesley Jongen, *The Impact of the Long-Term Care Reform in the Netherlands: An Accompanying Analysis of an ‘Ongoing’ Reform*, Ph.D. Dissertation, Maastricht University, 2017, <https://cris.maastrichtuniversity.nl/portal/files/7345428/c5595.pdf>.
- <sup>6</sup>Peter Alders and Erik Schut, “*The 2015 Long-Term Care Reform in the Netherlands: Getting the Financial Incentives Right?*” *Health Policy* Vol. 123, Nr. 3 (2019): 312-316, <https://doi.org/10.1016/j.healthpol.2018.10.010>
- <sup>7</sup>Pieter Bakx, Erik Schut, and Bram Wouterse, “Price Setting in Long-Term Care in the Netherlands,” Erasmus School of Health Policy and Management, November 2020; Wesley Jongen, *The Impact of the Long-Term Care Reform in the Netherlands: An Accompanying Analysis of an ‘Ongoing’ Reform*, Ph.D. Dissertation, Maastricht University, 2017, <https://cris.maastrichtuniversity.nl/portal/files/7345428/c5595.pdf>.
- <sup>8</sup>Hongsoo Kim and Soonman Kwon, “A Decade of Public Long-Term Care Insurance in South Korea: Policy Lessons for Aging Countries,” *Health Policy* Vol. 125, Nr. 1 (2021): 22-26, <https://doi.org/10.1016/j.healthpol.2020.11.003>; PwC, “Republic of Korea: Social Security Contributions,” accessed November 21, 2020, <https://taxsummaries.pwc.com/republic-of-korea/individual/other-taxes>.
- <sup>9</sup>Washington State Legislature, “Long-Term Services and Supports Trust Program,” Chapter 50B.04 RCW, 2019, <https://app.leg.wa.gov/RCW/default.aspx?cite=50B.04>. xiii Jon Kvist, “ESPN Thematic Report on Challenges in Long-Term Care: Denmark,” European Social Policy Network, 2018, <https://ec.europa.eu/social/BlobServlet?docId=19844&langId=en>.
- <sup>10</sup>Pär Schön and Josephine Heap, “ESPN Thematic Report on Challenges in Long-Term Care: Sweden,” European Social Policy Network, 2018, <https://ec.europa.eu/social/BlobServlet?docId=19870&langId=en>.
- <sup>11</sup>Edith Bocquaire, “Long Term Care Coverage in Europe,” *Long-Term Care News*, Society of Actuaries, Issue 41, May 2016, <https://www.soa.org/globalassets/assets/Files/Pubs/pub-2016-05-ltc-coverage-europe.pdf>.
- <sup>12</sup>Blanche Le Bihan, “ESPN Thematic Report on Challenges in Long-Term Care: France,” European Social Policy Network, 2018, <https://ec.europa.eu/social/BlobServlet?docId=19847&langId=en>.

## Appendix 2: Consultations

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## Appendix 3: Sources and Search Strategy

### Databases

#### COVID-Specific Resources

- LitCovid
- CEBM
- WHO COVID-19 Global Literature
- CIHI-Covid collection
- COVID-END
- Cochrane COVID-19 Study Registry

#### Clinical Practice Guidelines Resources

- ECRI Institute
- NICE Guidance

#### Knowledge Synthesis Databases

- Health Systems Evidence
- TRIP
- Google Scholar

#### Grey Literature Sources

- LTC Responses to COVID-19 by the International Long-Term Care Policy Network
- COVID-19 Health System Response Monitor
- European Centre for Social Welfare Policy and Research

#### Search terms

Concept	Search terms
Home care	Home care, home-based care, care-at-home, in-home care, aging-in-place
Caregivers	Home caregivers, informal caregivers, family caregivers, unpaid care, unpaid careers,
Older adults	Old, Older, elder, elderly, aging,

**Example:** The WHO COVID-10 Global Literature on Coronavirus Disease  
 Search string: (tw:(home care)) OR (tw:(care at home)) AND (tw:(older adults))  
 Results: 214